



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-08-7244-01
NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
SEABRIGHT INSURANCE CO Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of \$1954.06 for APC # 0154. Allowing this at 140% would yield a fair and reasonable allowance of \$2735.68...Also the HPCPC's 71020 & 93005 would allow \$65.40, which they allowed no payment on as well." [sic]

Amount in Dispute: \$3402.46

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,100.00 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1/24/2008	16, 855-022, 97, 855-013, W1, 663, 45, 900-031, 18, 999	Hospital Outpatient Services	\$3402.46	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 14, 2008.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - 16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code.)
 - 855-022-Charge denied due to lack of sufficient documentation of services rendered.
 - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 855-013-Payment denied-The service is included in the global value of another billed procedure.
 - W1-Workers Compensation state fee schedule adjustment.
 - 663-Reimbursement has been calculated according to state fee schedule guidelines.

- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability).
 - 900-031-Provider does not participate in the TX WC HCN.
 - 18- 18-Duplicate claim/service.
 - 999-\$25.44 of the charges are duplicate of bill #88888958-H-720450-1
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
 3. The Respondent raised the issue of a PPO contract; however, a review of the submitted EOBs does not support a PPO reduction was taken. Neither party submitted a copy of a contractual agreement to support this EOB denial; therefore, the disputed services will be reviewed in accordance with Division rule at 28 TAC §134.1.
 4. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
 5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
 7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement states that: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of \$1954.06 for APC # 0154. Allowing this at 140% would yield a fair and reasonable allowance of \$2735.68...Also the HPCPC's 71020 & 93005 would allow \$65.40, which they allowed no payment on as well." [sic]
 - The requestor does not discuss or explain how payment of 140% of Medicare allowable would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
 - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division

concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

10/18/2010

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.